Testimony to the Little Hoover Commission

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September 28, 2006

Thank you for the invitation and opportunity to testify. ITUP (Insure the Uninsured Project) has just completed its 10-year retrospective on California and the uninsured and our annual report on health care, coverage and financing for low income Californians. We also publish a report on demographics, community clinics, hospitals, health plans and counties for 48 of the state's 58 counties, in addition to six regions, encompassing the entire state. Our testimony responding to the questions you have posed is based on these reports, which are posted at www.itup.org.

California's health care system for the uninsured has a number of strengths as compared to many other states. Among them are the following:

1. Strong safety net community clinic systems in nearly every county.
    a) On average California's 808 community and free clinics deliver 0.8 visits per uninsured California resident at a cost of $711 million.
    b) Insured individuals average 3.6 visits annually.
    c) Financing for clinics' care to the uninsured comes from a mix of sources: Family PACT, counties, federal 330 grants, state EAPC funds and patient contributions.
    d) Over the past ten years, clinic visits to the uninsured have been increasing, as have most of these funding sources.

2. Strong public hospitals in many of the state's largest counties.
    a) Large public hospital systems account for most of the state's hospital-based services to the uninsured.
    b) State and federal funding for their care to the uninsured has increased at least commensurate with their actual care to the uninsured.
    c) Many of the counties with county hospitals are slowly expanding their outpatient care to the uninsured while maintaining their volumes of inpatient days and emergency visits.
    d) Many county hospitals have re-built or are re-building their facilities to meet state seismic safety standards.

3. County responsibility for care to the uninsured indigent is funded in large measure by the state and federal governments.
    a) California counties are responsible under law for care to uninsured indigent adults. In toto, they spend about $1.8 billion on care to 1.3 million uninsured patients.
    b) Counties are slowly expanding their outpatient care to the uninsured (.6 visits per uninsured) while maintaining their volumes of inpatient days (77 days per 1000 uninsured) and emergency visits (78 visits per 1000 uninsured).

c) Counties receive state (realignment and Prop 99), federal (net county DSH, net county SB 1255 and Safety Net Pool) and local funding (county match and tobacco litigation settlement) to support county health programs.
d) The slow growth in these funds has exceeded county spending on care to the uninsured.

4. Pioneering local efforts to increase coverage of the uninsured.
    a) Pioneering local efforts to increase coverage for the uninsured have sprung up from San Diego to San Francisco and from Alameda to Tulare.
    b) Many involve expanded coverage for uninsured children – the Healthy Kids programs. Some involve partnerships between local county government, small businesses and low-wage workers – SacAdvantage in Sacramento County and FOCUS in San Diego to cover uninsured adults through the work place.
    c) Others cover discrete working populations such as home care workers, child care businesses, or taxi-cab drivers in San Francisco.
    d) Others would cover young adults (San Francisco) or working families (Alameda).
    e) Most are based in county operated managed care plans for Medi-Cal and Healthy Families enrollees, seeking to develop new models and markets among the uninsured.

5. Broad eligibility for and enrollment in Medi-Cal and Healthy Families, for pregnant women and children in particular.
    a) Medi-Cal and AIM cover prenatal and deliveries for all pregnant women up to 300% of the federal poverty level.
    b) Medi-Cal and Healthy Families cover children up to 250% of FPL. As a result, less than 4% of births in California are to uninsured women, and at a given point in time fewer than 8% of California's children are uninsured.
    c) With the advent of and strong support for local Healthy Kids programs that cover uninsured children not otherwise eligible for state programs, counties such as San Mateo, San Francisco and Santa Clara have reduced their percentage of uninsured children to 1-2%.

6. A very cost effective Medi-Cal program with strong support for safety net providers.
    a) Medi-Cal covers a broad range of services for nearly 6.7 million Californians at one of the lowest costs per eligible in the country.
    b) The low cost is associated with many factors: low use of nursing homes, tight utilization controls, hospital contracting, prescription drug rebates, and broad enrollment of most families in Medi-Cal managed care.
    c) Medi-Cal also provides strong financial support for community and county outpatient clinics through FQHC reimbursement and for public and private hospitals care to the uninsured through the federal DSH program.
    d) The low per capita costs make Medi-Cal and Healthy Families expansions financially attractive.

e) Healthy Families, which is not encrusted with 40 years of state and federal rulemaking, is a far simpler program for beneficiaries, plans and providers than Medi-Cal.

7. A high percentage of businesses that continue to offer coverage despite hefty premium increases.
    a) Ten years ago, California employers offer rates were well below the national average.
    b) In a recent CHCF report, California employers' offer rates now exceed the national average.
        - This turn-around is due in large measure to a greater decline in offer rates in other states while California employers have held reasonably steady.

8. High enrollment of employees in commercial HMOs that are more cost efficient than in other states.
    a) California HMOs are more cost effective than the national average, and a higher percent of California employees are enrolled in HMOs.
    b) This contributes to making California attractive for those companies offering generous benefit packages for their employees.

9. An unexpected rate of hospital bad debt and charity care.
    a) With 20% of Californians under the age of 65 uninsured, one would expect California hospitals to have a very high rate of bad debt and charity care for the uninsured.
    b) While that is absolutely true in some hospital emergency rooms, the overall burden of uncompensated care to the uninsured is about 3% of hospital expenses.
    c) This surprisingly low rate of bad debt and charity care to the uninsured is due to several factors:
        1) The responsibility of county health for indigent uninsured adults,
        2) MediCal coverage for disabled low income adults
        3) Medi-Cal's monthly "share of cost" eligibility for families and the disabled
        4) Medi-Cal's coverage of emergency services for the undocumented,
        5) Medi-Cal and AIM's coverage of maternity services
    d) A well-tailored expansion needs to wrap-around rather than replace or supplant existing state and federal programs covering the uninsured for specific services and illnesses.

10. Reforms in small employers' purchase of health coverage.
    a) California's reforms established guaranteed issuance and renewals of coverage for small employers with 2-50 employees, limits on exclusions based on pre-existing conditions and rate bands (i.e. restrictions) on the pricing of coverage based on medical underwriting.

b) These reforms afford transparency and certainty on the price of coverage and facilitate informed comparison-shopping by small businesses.

California's health system for the uninsured has serious weaknesses as well:

1. Large and unsustainable increases in health premium costs for employers and employees.
    a. A decade ago, health costs and premium increases were at or below the increases in workers wages; over the decade the rate of health inflation has increased to 3, 4, 5 and sometimes 6 times as high as worker's wage increases.
    b. This creates severe economic distress for low wage workforces and for their employers.

2. Weak ability of counties and the state government to raise revenues to pay for needed program improvements due in part to lack of bi-partisan consensus and to voter imposed limits on raising taxes and ballot-box budgeting.
    a. Proposition 13 rolled back and froze counties abilities to raise local property taxes to pay for local programs.
    b. Counties now depend heavily on state realignment (a portion of the state sales tax and vehicle license fees) to fund county health.
    c. Two-thirds vote requirements, the absence of bi-partisan consensus and interest groups' shift to ballot box budgeting to escape the strictures of partisan gridlock have wrought havoc on state government's ability to rationally budget for today's priorities and plan for tomorrow's needs.

3. Healthy Families parents uninsured.
    a. The federal government approved a waiver for California to expand the Healthy Families program (2/1 match) for uninsured parents up to 200% of FPL.
    b. It remains unimplemented and unspent federal S-CHIP funding was re-distributed to other states due to California's inability to make the then $100 million state General Fund match.
    c. Federal Medicaid funds (1/1 match) are still available to California to make this an important investment in coverage for working families.

4. Poor reimbursement for physician services.
    a. The worst Medi-Cal reimbursement is for physician and other professional services, resulting in particularly poor access to specialty services.
    b. Few if any rate increases have been approved for most physician services (other than obstetrics) for the past twenty-five years.
    c. Unlike all other services, reimbursement rates for professional services have experienced little or no increase; this is mitigated somewhat by the shift of families to managed care and the Medicare reimbursements available to physicians who treat those with dual eligibility.

5. Disconnect between the state health programs for low-income families, disabled and elderly adults and the county health programs for indigent adults.

a. In 1983, California terminated Medi-Cal coverage for indigent adults and returned them to county responsibility with limited state funding.
b. Since then ten states have sought and secured federal waivers and federal matching funds to expand Medicaid coverage to adults – including the neighboring states of Arizona and Oregon and Northeastern states such as Massachusetts and New York – California has not.
c. Medi-Cal operates somewhat uniformly with the same eligibility and benefits for residents of all 58 counties.
d. County health has the same eligibility, services and reimbursement rates in 34 very small counties and radically different (from each other and from Medi-Cal) eligibility, services, delivery systems and reimbursement rates in each of the remaining 24 large counties.

6. Inadequate and inequitable funding for county health programs for indigent adults and large deficits in their delivery of outpatient services to uninsured adults. ITUP compared and contrasted funding and services for county health programs.
    a. County health programs are funded at on average $453 per uninsured county resident – less than 1/6th the annual cost of a typical commercial HMO.
    b. Funding per uninsured county resident had a variation of 9-1 among the 48 counties that were part of our report.
    c. In general, access and use of services by the uninsured was much stronger in the best-funded counties.
    d. We found variability from county to county in reported use of inpatient services, ranged from 10 to 1 (12 days per 1000 to 190 days per 100; averaging 70 inpatient days per 1000 uninsured) and variability in reported use of outpatient services ranged from 10 to 1 (averaging .6 visits per uninsured). Insured adults average 250 inpatient days per 1000 in a well-operated California HMO.
    e. Some counties reimburse community clinics for their care to the uninsured – typically averaging 30% of community clinics' uninsured revenues; others do not; some counties pay only for hospital based outpatient services.
    f. Given the vast under-funding of their mission, county health programs spend a far higher percentage of their resources on acute inpatient and emergency services than does a typical HMO.

7. Silo funding for public hospital, private hospital, community clinic, and private physician services to the uninsured and disconnected delivery systems.
    a. In California, each type of provider of services to the uninsured has its unique, underfunded and jealously guarded pot of revenues.
    b. Private physicians have SB 12; community clinics have EAPC (Expanded Access to Primary Care); private hospitals have virtual DSH; and public hospitals have DSH and Safety Net Pool funding.

8. Multiplicity of disconnected programs and funding streams and confusion and lack of transparency and accountability of providers and program administrators.

a. Clinic, hospital and county administrators each must deal with dozens of over-lapping and inconsistent programs, funding streams and reporting requirements for their care to the uninsured and other low-income patients.
b. Only a treasured few financial and program wizards understand the intricacies of these programs, leading to widespread confusion and lack of accountability to patients and public oversight.

9. Few reforms of the individual insurance market.
    a. This remains a market with higher prices for fewer benefits and inadequate consumer protections as compared to the market for small employers.
    b. The state's program for medically uninsured individuals (who are denied coverage due to health status) is subsidized at the same insufficient amount ($40 million from Proposition 99) as it was when established more than 15 years ago.

10. Lack of consistent vision, statesmanship, political will and leadership in resolving health system challenges for the uninsured.
    a. California lawmakers and stakeholders have been wrestling with program reforms designed to cover the uninsured for nearly 20 years.
    b. Multiple ballot initiatives and major reform bills with staunch support and strenuous opposition from different constituencies have been introduced and defeated in turn.
    c. Modest progress has nevertheless occurred, primarily driven by the availability of FFP (Federal Financial Participation) in Medicaid and S-CHIP (State Child Health Insurance Program).

Over-all health reform should include the following components:

1. Basic health coverage for every Californian. There are certain basic and essential health benefits without which we, as often healthy and sometimes ill, individuals in a modern society cannot function; these include: doctors, hospital services and prescription drugs.
    a. This does not include every service or treatment a physician or hospital can provide nor does it include every medication, regardless of cost or efficacy.
    b. Basic coverage should be available to all for only those cost-efficient and medically efficacious services.

2. Cost controls which ensure premium stability.
    a. California, the nation and other states have tried an array of regulatory controls and market experiments to control the rise in health spending.
    b. Each approach works well for a time, then is overcome, and health expenditures soar again.
    c. In our view, it probably will require a budget or expenditure cap to achieve program efficiencies and restrain unchecked growth.

3. Incentives for providers, plans and consumers.

a. Providers respond to fee for service and to usual and necessary cost reimbursement by increasing costs and services and to capitation by decreasing them.
b. Consumers respond to high copays and deductibles by decreasing their use of care – at times to the disadvantage of their health -- and respond to no co-pays by increasing their use of services.
c. Plans profit by restraining the rise in health expenditures below the rise in their premiums.
d. The next round of health reform needs to properly align the financial incentives for patients, providers and health plans.

4. Rewards for quality and cost effectiveness.
    a. More is becoming known about provider quality, efficacy and cost-effectiveness. That information as well as information on provider and plan prices needs to be widely available to all participants
    b. Payment structures have to be developed and widely implemented based on the best information available and constantly updated as the information changes and technologies improve.

5. Markets where they work and rate regulation where competition fails.
    a. Managed competition as espoused by Prof. Alain Enthoven has worked in large urban markets (such as Los Angeles) to provide more affordable coverage.
    b. It does not work at all in one-hospital towns or communities dominated by a single provider network; and rate regulation or some other approach will likely be necessary to promote more affordable coverage in California's rural areas.

6. Equitable and adequate financing that maximizes federal contributions and promotes economic growth in Californians.
    a. Wherever feasible California should avail itself of the resources of the federal government. For low-income individuals, this means maximizing enrollment in Medi-Cal (1/1 match) and Healthy Families (2/1 match) and seeking an 1115 waiver for adults as discussed above, using existing county spending as the match.
    b. For higher income individuals, this means an emphasis on employment-based coverage for which favorable tax treatment is available, subsidizing 1/3rd of premium cost.
    c. For those, caught in between and unable to afford premiums, we should subsidize premiums using state funds. Any additional state financing needed for premium subsidies should be collected by applying the state sales tax to selected services, rather than through an increase in payroll taxes or an income tax surcharge.

Consequences of failure to reform system:

1. Damage to health status of the uninsured and public health hazards for the insured.
    a. The uninsured receive half as much care as the insured, often too little and too late to achieve optimum results.
    b. The uninsured are not a perpetual underclass of uninsured, invisible individuals, but rather a revolving door; uninsured status impacts many Californians at some point in their lives.
    c. Failure to diagnose and treat the uninsured for communicable diseases exposes all of the insured at work, at school, in movie theaters, transportation, restaurants, homes and throughout our daily lives to these diseases.

2. Uncompensated care to providers.
    a. Hospitals in our latest report have costs of uncompensated care to the uninsured of $1.5 billion or 3% of hospital expenses.
    b. Community clinics have costs of uncompensated care to the uninsured of $117 million or 11% of clinic expenses.
    c. National studies found that two thirds of private physicians devote on average two hours of their practice each week to care of the uninsured.

3. Cost shift to the private sector.
    a. A Families USA report found that uncompensated care to the uninsured adds a 10% cost shift hidden tax to private insurance premiums.
    b. We think the private hospital cost shift for their care to the uninsured in California is lower -- adding about $1.2 billion (or 2%) in costs to the $60 billion costs of private insurance.
    c. Public hospitals have too few privately insured patients to meaningfully contribute to the cost shift; their uncompensated care to the uninsured is paid for by state, local and federal taxes.

4. Cost pressures on state and county governments and impacts on global competitiveness of American businesses.
    a. State expenditures on care to low income Californians through Medi-Cal and Healthy Families have been increasing faster than state tax revenues.
    b. County health revenues increase at a far slower pace than the combination of medical care inflation plus the growing numbers of uninsured.
    c. Those American employers competing in the global marketplace carry added cost burdens not common to their foreign competitors: the costs of employment based coverage (over $500 billion) nationally, the costs of payroll taxes to finance Medicare, and the over-all high cost of America's health care system.
    d. Employers in countries that finance their health systems through a combination of income taxes and consumption taxes do not need to internalize comparable cost burdens in the costs of their products and services in global markets.

Uninsured – who are they and how do they get care:

1. Differing estimates of the uninsured.
    a. The uninsured are measured by the Current Population Survey (CPS) (6.8 million in 2005) and by the California Health Interview Survey (CHIS) -- 4.5 million in 2003.
    b. We think the CHIS estimate is far more accurate as the CPS vastly under-reports the numbers of Californians enrolled in Medi-Cal and Healthy Families.
    c. CHIS 2003 found 4.5 million Californians uninsured at a point in time and 6.5 million Californians experiencing one or more periods of uninsurance over the course of a year.
    d. A Families USA study found that over 11 million Californians experienced a spell of uninsurance over a two-year period.

2. Working men and women and their families.
    a. Over 75% of the uninsured are working men and women and their families.
    b. Employment-based coverage is purchased with pre-tax dollars; the financial advantage of this tax preference is a 30% tax subsidy of employment-based coverage as compared to individual coverage.
    c. The self-employed enjoy a similar tax preference (tax deductibility) when buying individual coverage.

3. Over half under age 30.
    a. Young adults have the highest rate of uninsurance – 30% uninsured.
    b. Like children, young adults are relatively less expensive to cover.

4. Nearly two thirds under 200% of FPL.
    a. For those with low incomes, public coverage is an option and a financial advantage for California as the federal government pays half the costs of Medicaid and two-thirds the cost of Healthy Families.

5. Nearly 3/4th are long term uninsured, while the rest are short term uninsured (lacking insurance from one to three months) in transition between jobs and different forms of coverage.
    a. The short term uninsured typically have higher incomes, better health status and a greater ability to contribute a portion of the costs of coverage.
    b. Retention (keeping coverage and creating affordable interim coverage for those in transition from job to job, welfare to work or during family dissolutions) should be a high priority and relatively administratively easy.

6. 5.6 million uninsured adults.
    a. Uninsured adults have been a low priority for California policy makers, and indeed when California in 1983 terminated Medi-Cal coverage for

"Medically Indigent Adults", it took a huge step in exacerbating the state's problems of the uninsured.

7. Equal numbers work for small businesses that do not offer coverage as work for large employers who do offer coverage.
    a. Professor Rick Kronick's research found that as many of the uninsured work for large companies (over 100) who offer coverage as work for small businesses (under 100) who do not offer coverage.
    b. The lack of employment-based coverage for workers involves three factors: offer rates (does an employer offer coverage), take-up rates (does the employee accept the coverage offered) and eligibility rates (is the employee part of a class of excluded workers for an employer who does offer coverage). The latter group could be new hires, probationary employees, part-time employees or excluded classes of workers such as sales, secretarial, floor, temps or contract workers.

8. Up to a million eligible but not enrolled in coverage for which they are eligible.
    a. Many children and some adults are eligible for programs, but for a variety of reasons not enrolled.

9. The uninsured pay for substantial amounts of their own care out-of-pocket, often at seriously inflated prices.
    a. The uninsured pay out-of-pocket for medical care, prescriptions, and hospital services.
    b. Because they are uninsured, individuals are billed for care at hospital charges, which are typically three to four times higher than hospital costs.

10. They receive about half as much care as the uninsured; **and** this includes emergency services.
    a. Half the care and the dollars for that care to the uninsured is already in the system; someone is paying -- the patient, tax-payers and the privately insured through the "cost shift".
    b. One way to reduce the costs of expanding coverage for the uninsured reform is to "capture" existing expenditures and apply them to the costs of covering the uninsured.

11. The uninsured seek too little care, too late to get the health benefits of timely medical interventions. They receive care from county health programs, community clinics, private hospital emergency rooms and doctors
    a. County health – 1.3 million uninsured patients at a cost of $1.8 billion
    b. Free and community clinics – 5.1 million uninsured patient visits at a cost of $710 million.
    c. Private hospitals -- $1.2 billion in costs of bad debt and charity care
    d. Private doctors – national average of two hours of care to the uninsured each week for two thirds of private physicians

Barriers to Reform:

1. ERISA (Employee Retirement Income Security Act). This is a federal law passed to respond to pension scandals and bankruptcies in the 1970s. To protect large multi state employers from having to meet differing and inconsistent standards in all 50 states, it includes a pre-emption of state regulation of employer's self insured plans and vests oversight instead in the US Department of Labor.
    a. In a Hawaii case brought by a multi state self insured plan against Hawaii's employer mandate, prescribing employer and employee shares of premium and minimum benefits packages, the US Supreme Court affirmed a lower court decision, barring that state's "employer mandate"
    b. Congress subsequently exempted the Hawaii statute from ERISA pre-emption.
    c. ERISA is a barrier to a state employer mandate, but probably not to a state payroll tax to partially fund health care for a state's citizens.

2. Catch 22. Some federal and state rules effectively constrain reform efforts to one step forward one step back by reducing state and federal financing for care to the uninsured as coverage is expanded.
    a. San Francisco's interesting design of its universal health access program seeks to avoid this trap by calling its expansion "access", not coverage.
    b. Massachusetts' individual mandate for universal coverage escaped this costly conundrum in the design of its federal 1115 waiver.

Where has progress occurred in California?

1. Pregnant women (covered up to 300% of FPL)
2. Children (covered up to 250% of FPL)
3. Parents (two parent working families and coverage extended up to 100% of FPL)
4. Safety net funding (funding for Disproportionate Share Hospitals' costs of care to the uninsured) and capital spending (state and federal subsidies for public hospital capital spending projects)
5. Public managed care (successful and competitive locally operated managed care plans leading pioneering local efforts to cover uninsured adults and certain categories of uninsured adults)
6. Family PACT (covers family planning services up to 200% of FPL).

Where has progress not occurred?

1. Cost controls (effectiveness of successful cost controls eroded)
2. Young adults (increasing percentages of uninsured healthy young adults)
3. Parents (failure to fund and implement federal waiver extending coverage for Healthy families parents up to 200% of FPL)

Road Map to Reform:

1. Marry coverage expansion with effective cost controls.
2. Maximize Federal Financial Participation (FFP) by seeking an 1115 waiver for low income adults, using a county match up to the extent of existing county program expenditures.

3. Mix and match employer and employee contributions with sliding fee public subsidies to make coverage affordable for the moderate income uninsured.
4. Maximize federal tax advantages (build on employment based coverage) for higher income working uninsured where possible, while understanding that the tax subsidy associated with employment based coverage is most important to higher income workers and their families.
5. Universal coverage will require employer and individual mandates with subsidies to assure affordability or taxes to which everyone contributes.